



8515 GEORGIA AVENUE, SUITE 400  
SILVER SPRING, MARYLAND 20910-3492  
301 628-5000 • FAX 301 628-5001  
www.NursingWorld.org

KAREN A. DALEY, PhD, MPH, RN, FAAN  
PRESIDENT

MARLA J. WESTON, PhD, RN  
CHIEF EXECUTIVE OFFICER

December 3, 2010

Donald Berwick, MD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1345-NC  
P.O. Box 8013  
Baltimore, MD 21244-8013

Submitted electronically to <http://www.regulations.gov>

**Re: Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program**

CMS-1345-NC (Posted November 17, 2010).

Dear Administrator Berwick:

The American Nurses Association (ANA) welcomes the opportunity to offer comments on the formation of Accountable Care Organizations (ACOs) as a provision of the Affordable Care Act (ACA) of 2010.

The ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses (RNs), the single largest group of health care professionals in the United States. We represent RNs in all roles and practice settings, through our state and constituent member nurses associations, and organizational affiliates. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and advocating before Congress and regulatory agencies on health care issues affecting nurses and the public. Our members include Advanced Practice Registered Nurses (APRNs) such as Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs).

ANA is a vigorous supporter of the ACA's potential to revolutionize the way healthcare is delivered, experienced, and paid for in America. We see the Accountable Care Organization (ACO), as stipulated in ACA, as a concept that can help fulfill that vision. Nursing is energized about the immense opportunity to improve the healthcare journey

in America, and ANA sees the ACO as a new frontier. This is a pivotal moment to restructure the payment systems, quality assurance enterprises, and the antiquated hierarchy of healthcare professionals to reward truly interdisciplinary care.

As models of ACOs are developed and tested, ANA believes the following elements should be in place:

### **Nurses are leaders in care coordination – a priority for ACOs**

The coordination of care is at the heart of any successful ACO and should be one of the required activities contributing to quality care and cost-savings of ACOs. Care coordination is frequently mentioned in the ACA, yet few provisions explicitly authorize payment, although some give preference to coverage or programs that include coordination of care among their considerations.

Despite its prominence in ACA, this important concept of “coordination of care” is never adequately defined. The new statutory and market-based emphasis on coordination of care is meant to improve the quality and safety of care that patients receive, and to reduce or eliminate redundancies and unnecessary care that contribute to the high cost of care and also threaten patient safety. Nursing care contributes directly to these aspects, yet nursing costs have been rolled into “room charges” and overhead for purposes of reimbursement, thus rendering nursing’s contributions invisible. These formerly invisible or “included” services will now see new light if care coordination is adequately identified and measured. If nursing services are to be individually identified, measured and evaluated, it would represent one way the Secretary is measuring quality.

Entities outside of the federal government have taken great strides in demarcating what is “coordination of care,” assigning specific functions and services to the nomenclature and continuing to develop quality measures and parameters describing the coordination of care. Quality-focused organizations, as well as the nursing profession itself, can offer specific measures as a springboard for the Secretary’s determination of quality and performance standards in evaluating ACOs for potential shared savings (sec. 3022), as well as various models emerging from the Center for Medicare and Medicaid Innovation (sec. 3021).

We urge CMS, in developing principles for ACOs, to recognize both the central role that care coordination plays in ACOs, and the integral contributions of RNs to patient care coordination. Care coordination is an essential part of all RN practice, and is one of the standards of professional practice for nurses. The standard stipulates that “the registered nurse coordinates care” and demonstrates competency to this standard when he or she:

- Organizes the components of the plan.

- Manages a healthcare consumer's care in order to maximize independence and quality of life.
- Assists the healthcare consumer in identifying options for alternative care.
- Communicates with the healthcare consumer, family, and system during transitions in care.
- Advocates for the delivery of dignified and humane care by the inter-professional team.
- Documents the coordination of care.<sup>1</sup>

Examples of care coordination as a role in nursing are Case Managers employed by hospitals, health insurance companies and other health care entities; school nurses; public health nurses; home care nurses who are RNs; and Nurse Case Management. In fact, these are recognized areas of specialization within the nursing profession. The unique competencies of these areas of practice can be translated into unique roles in ACOs that coordinate care from hospital to home to community. The ACO also provides an exciting opportunity to carve out independent new functions for nurses, fulfilling the recommendation of the Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health* that nurses take on reconceptualized roles as health coaches, informaticist, health team leaders, and primary care providers.<sup>2</sup>

### **Care Coordination Is Adequately Compensated**

A cornerstone of the ACO concept is the heightened and improved coordination of patient care, to increase quality and efficiency and to decrease costs. It is a well-recognized axiom of healthcare management that uncoordinated care leads to disjointed, duplicative, unnecessary, and ineffective care, lengthening treatment time and hospital stays, and resulting in increased costs which are unrelated to increased benefits for the patient. Such waste and inefficiency only serves to decrease the resources available for other patients. Care coordination therefore makes sense as a required cost savings activity, and, if conducted in concert with small, solo, or community-based practices, could be an opportunity for these practices to access capital as they participate meaningfully in ACOs.

CMS has asked for ideas on alternative payment methods and measuring caregiver and beneficiary satisfaction. A reformed payment system needs to create financial incentives for hospitals and other healthcare organizations to hire RNs to provide care coordination and transitional care. It would be consistent with the purpose and goals of

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<sup>1</sup> American Nurses Association. (2010). *Nursing: Scope and Standards of Practice, 2<sup>nd</sup> Edition*. Silver Spring, MD: Nursebooks.org.

<sup>2</sup> Institute of Medicine (IOM). 2011. *Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press. p. F-13.

the ACO language included in the Act to provide those incentives to employ RNs in care coordination.

The IOM report, *The Future of Nursing; Advancing Health, Leading Change* noted that:

“There are few integrated delivery systems or ACO-type entities that are responsible for, and explicitly rewarded for, their overall performance across the settings that comprise their system of care rather than a single setting. In the main, financial performance is captured and rewarded at the level of the individual setting (e.g., hospitals) and not at the system level (e.g., ACO), so the behavior of each setting is independent and driven by its own goals. Consequently, hospitals lack the financial incentive to hire and deploy RNs to provide transitional care if the outcome is reduced income in the form of reduced admissions. ACO-type organizations lack the incentive to employ RNs to provide care coordination and team management services if these entities are not rewarded for improved financial performance and quality outcomes that these services produce.”<sup>3</sup>

We believe that if care coordination is truly a priority in the evolving healthcare system, then its value must be recognized in the form of full and adequate compensation. We urge CMS to support this tenet in the developing proposed rule.

### **Quality is Evaluated in Part By Measuring Care Coordination and Nursing-Sensitive Indicators**

CMS has asked for ideas on what quality measures should be required of ACOs. ANA urges that ACOs be required to participate in the collection of data for nurse-sensitive quality measures using a database such as the National Database of Nursing Quality Indicators™ to be eligible for shared savings payments. Nurse-sensitive quality indicators should be included across the care continuum capturing structural, process, and outcome measures which contribute to achieving patient-centered health outcomes. These might include prevention of avoidable adverse events (e.g., pressure ulcers, falls, medication errors of omission and commission, and emergent care).

The reliance on care coordination to streamline the health care experience, to be adequately reimbursed, must be measured. Preliminary exploration by leading national quality-oriented organizations provides instructive guidance. Specifically, the National Quality Forum (NQF) adopted, and ANA supported, *Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report*. This report establishes National Voluntary Consensus Standards for Care Coordination. In

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<sup>3</sup> Institute of Medicine. 2011. *Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press. p. F-13.

particular, its “care coordination” measures and preferred practices identify the importance of the healthcare home selected by the patient, a proactive plan of care and follow-up, interdisciplinary team collaboration that includes the patient, health information technology systems that support the team, and coordinated transitional care.

Moreover, the National Priority Partnership (NPP) developed a Coordination of Care Action Plan which incorporates NQF-endorsed care coordination and transitional care preferred practices, including recommendations by leading nurse experts in transitional care.<sup>4,5</sup> ANA co-chairs the NPP Care Coordination Committee in the important work of identifying drivers of change to improve care coordination, which include recommendations for performance-based payment and public reporting.

As noted before, many of these services are largely furnished by registered nurses, whose value has been rolled into “room and board” charges in the hospital setting. In order to fairly evaluate the costs and resources invested in patients, as well as cost savings achieved through improved outcomes, coordination of care services must be teased out at the coding level. ANA has provided input to the NQF’s Health IT Utilization Expert Panel as to the need for precision and clarity in terms, relationships, and definitions to ensure Electronic Health Record (EHR) usability and reduce unintended workload for nurses and other interdisciplinary team members. Moreover, appropriate clinical decision support or evidence-based care, which includes care coordination and transitional care, is necessary. The end user of any data must be part of the development of any EHR to ensure the intended outcomes of that information is meaningful.

### **Strong Leadership from and among all Healthcare Professionals**

CMS has asked for elements of an ACO that reflect patient-centeredness, and ANA believes that development, structure and governance of ACOs are such aspects. Equitable representation of physicians, nurses, and other health professionals on ACO leadership structures help to develop and nurture patient-centered care. While efforts to define and measure patient centeredness continue, it is clear that “care that is respectful of and responsive to individual patient preferences, needs, and values,”<sup>6</sup> requires collaboration between members of an interdisciplinary/interprofessional team.

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<sup>4</sup> National Quality Forum (NQF). (2010). *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report*, Washington, DC: NQF.

<sup>5</sup> Naylor, M.D., Kurtzman, E.T. (2010). The role of nurse practitioners in reinventing primary care. *Health Affairs*. 29(5):893-9.

<sup>6</sup> IOM. (2001). *Crossing the quality chasm: A new health system for the 21<sup>st</sup> century*. Washington, DC: The National Academies Press.

In today's rapidly evolving health care system, that team includes professionals whose role and care modalities (e.g., telehealth) have evolved, and those professionals provide care in settings across the care continuum that continue to evolve outside the once-dominant hospital.

Therefore, in order to be truly patient centered, ACOs should be structured in ways that 1) utilize all health care professionals to the full extent of their education and training, and 2) facilitate interprofessional collaboration as patients transition across settings.

In fact, ANA recommends CMS consider implementing policy requiring ACOs to demonstrate that all healthcare professionals are permitted to practice to the full extent of their training, skills and scope of practice. This is one of the options the federal government can exercise to maximize the value of APRNs.<sup>7</sup> With an increasing understanding of overlapping scopes of practice and the importance of team-based care, outmoded hierarchical structures are giving way to innovative models that respect patient's choices in care. The focus needs to be on the care being provided, not the professional providing the care.

Provider neutral language, as opposed to insistence on "physician-led" care, respects the right of the patient to choose the type of provider he or she wants. When the National Partnership for Women & Families convened a group of more than 25 consumer, labor and advocacy groups to develop *Principles for Patient and Family Centered Care*, the resulting document states the care team is not necessarily "physician-led"; rather, the choice of leadership by a physician, nurse practitioner, or other clinician should belong to the patient and family. The IOM report on the future of nursing states:

ACOs that use APRNs and other nurses to the full extent of their education and training in such roles as health coaching, chronic disease management, transitional care, prevention activities, and quality improvement will most likely benefit from providing high-value and more accessible care that patients will find to be in their best interest.<sup>8</sup>

The report also recommends that nurses be full partners with physicians and others in redesigning the healthcare system in America, and be represented on decision-making

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<sup>7</sup> Safriet, B. (2010). Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care. Appendix contained in IOM *Future of Nursing: Leading Change, Advancing Health*.

<sup>8</sup> Institute of Medicine. 2011. *Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press. p. 3-41.

bodies and boards to ensure a balanced debate of the aspects of finance, medicine, and patient advocacy.<sup>9</sup>

### **Policies for Small and Solo Practices are Elastic and Create Synergistic Relationships**

CMS has asked what policies are needed to ensure small and solo practice participation. ANA urges care when further delineating statutory eligibility requirements so as to allow a wider segment of small, solo, and nurse-led practices to participate. Many small practices have limited patient panels. Setting a minimum number of beneficiaries as an individual eligibility requirement would create an insurmountable barrier for these practices to participate in the larger entity with the statutorily required minimum of 5,000 beneficiaries. In addition, eligibility requirements should not directly or indirectly exclude nurse-led primary care practices and programs, many of which are providing care to the medically underserved.

Policies or new payment incentives that would entice small practices include rewarding accreditation and providing the ability to function in networks. Practices operating as primary healthcare homes that attain National Committee for Quality Assurance (NCQA) recognition or its equivalent should be rewarded with financial incentives - boosting quality assurance of participating practices and their access to needed capital. NCQA includes nurse-led practices in its recognition program, assuring that they are qualified additions to the ACO.

Additionally, CMS should adopt policies supporting the development of networks to attract small practices that are otherwise resource limited. For example, the Durham Community Health Network in central North Carolina has 14 networks of 1,300 practices comprising upwards of 4,000 providers. The network allows shared access to RNs, care managers, social workers, nutritionists and community health workers, providing key services many practices would be otherwise unable to offer their patients. Networks offer access to resources and financial incentives, which foster small practices' participation and thereby increase the cumulative benefit of the ACO concept.

### **Demonstrate patient-centeredness by respecting patient choice of provider and shared decision-making**

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<sup>9</sup> Institute of Medicine. 2011. *Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press.

CMS has asked what concepts are critical to achieving patient-centered care. It is important that ACOs approach patient-centeredness as care that is organized around and responsive to the needs, preferences and experiences of the individual. Patient choice is the foundation of patient-centeredness, and is achieved when health care providers and patients engage in shared decision-making for a plan of care. In shared decision-making the provider understands the patient's perspective and the patient understands the options for and potential consequences of accepting or not accepting treatment recommendations.<sup>10</sup>

A positive patient experience correlates with improved patient involvement with care and clinical outcomes, patients remaining in a practice, reduced malpractice risk, and improved employee satisfaction. The patient experience may also provide information that serves as a basis for improving quality of care at a systems level.<sup>11</sup> Evaluation of patient-centeredness should include both patient satisfaction and understanding of the patient experience.

There is an applicable model for evaluating patient-centeredness. The Consumer Assessment of Healthcare Providers and Systems (CAHPS), a nationally recognized and validated tool that measures patient satisfaction. ANA recommends the Hospital survey as a model, since it evaluates patient satisfaction in relation to nursing care. One adjustment that ANA urges to the CAHPS however, is ensuring that survey questions or instruments use provider-neutral language. This reflects the diversity of professionals that lead an individual's care, especially APRNs, and ensures representative evaluation of the patient experience.

The Agency for Healthcare Research and Quality's National Healthcare Quality Report measures the experience of patient centeredness by evaluating if healthcare providers usually listened carefully, explained things clearly, respected what patients had to say, and spent enough time with patients.<sup>12</sup> These measures should continue to be used.

CMS has asked for ways to measure beneficiary satisfaction. ANA encourages evaluating the patient's beliefs about the outcomes of health care he or she received as a patient-centered way to achieve that. Self-reported data should include whether care improved quality of life, reduced untoward symptoms such as pain, enhanced use of

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<sup>10</sup> Elwyn, G., Edwards, A., & Britten, N. (2003). "Doing prescribing": How doctors can be more effective. *BMJ*, 327, 864-867.

<sup>11</sup> Browne, K., Roseman, D., Shaller, D., & Edgman-Levitan, S. (2010). Measuring patient experience as a strategy for improving primary care. *Health Affairs*, 29(5), 921-925.

<sup>12</sup> Agency for Healthcare Research and Quality. (2009). National Healthcare Quality Report, 2009. Retrieved on December 1, 2010 from [http://www.ahrq.gov/qual/grdr08/measurespec/patient\\_centeredness.htm#expcarmt1](http://www.ahrq.gov/qual/grdr08/measurespec/patient_centeredness.htm#expcarmt1)

treatments and technologies, and promoted interest in adopting positive health behaviors. Some of this data can be collected during clinical trials, observational studies and the Patient-Reported Measurement Information System NIH-supported initiative that is designed to develop improved systematic methods to measure quality of life and symptoms.<sup>13</sup>

In conclusion, the ACO is a new frontier in creating an engaging patient-centered quality delivery system, and ANA is enthusiastic to see healthcare enter this transformational realm. We appreciate the opportunity to comment on this important aspect of ACA.

If we can be of further assistance, or if you have any questions or comments, please feel free to contact Cynthia Haney, Esq., Senior Policy Fellow, Department of Nursing Practice and Policy, at [Cynthia.haney@ana.org](mailto:Cynthia.haney@ana.org), or 301-628-5131.

Sincerely,



Marla Weston, PhD, RN  
Chief Executive Officer  
American Nurses Association

cc: Karen Daley, PhD, MPH, RN, FAAN  
President, American Nurses Association

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<sup>13</sup> Wu, A.W., Snyder, C., Clancy, C.M., & Steunwachs, D.M. (2010). Adding the patient perspective to comparative effectiveness research. *Health Affairs*, 29(10), 1863-1871.